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Preference for Information and Coping Styles in Treatment-Seeking Delay for Symptoms of Acute Myocardial Infarction

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Introduction

Acute myocardial infarction (AMI) is experienced by nearly 1.5 million Americans each year (National Heart, Lung, and Blood Institute (NHLBI), 2004). This serious cardiac event commonly referred to as a “heart attack” has a long list of common risk factors and is prominent in both men and women. Its symptoms should be acted on immediately. Research has shown that rapid treatment of AMI greatly reduces morbidity and mortality, and therefore, enhances overall patient outcome. The use of reperfusion techniques such as thrombolytic therapy and emergency percutaneous transluminal coronary angioplasty (PTCA) can be used, with the best advantage, shortly after onset of AMI symptoms, preferably within two hours (Zerwic, 1999). Longer delay time to hospital presentation for AMI symptoms has shown to be associated with decreased use of such therapies (Moser, McKinley, Dracup, & Chung, 2003), therefore increasing morbidity and mortality. Unfortunately, many patients miss the window of opportunity for treatment due to pre-hospital treatment-seeking delay. Recent studies have reported median delay times ranging from 1.5 to 6.5 hours and mean delay times ranging from 4 to 24 hours (Dracup & Moser, 1991).

Delay to hospital presentation for heart attack symptoms has been well documented in both men and women. A difference in time delay between genders has not been found (Moser et al., 2003). However, other variables shown to be related to longer delay include history of coronary artery disease, older age, history of diabetes, and chronic atrial fibrillation (Berton, Cordiano, Palmieri, Guarieri, Stefani, & Palatini, 2001). Common reasons identified for increased delay reported by AMI patients include lack of recognition of cardiac symptoms, lack of recognition of symptoms as serious, denial, and embarrassment (Finnegan, Meischke, Zepka, Leviton, Meshak, & Benjamin-Carter et al., 2000). The most logical intervention for health care professionals to reduce this problem is to provide pertinent information to patients regarding heart attack symptoms and treatment protocol, especially those with existing cardiac risk factors. Mass media educational campaigns both in the United States and over seas,

however, have not led to improvements in delay. Several reasons may have contributed to their failure. First, such programs have been focused on knowledge. While knowledge of heart attack risk factors, signs, and symptoms is certainly important, knowledge alone has consistently failed to greatly impact time to presentation for treatment (Ho, Eisenberg, Litwin, Schaeffer, & Damon, 1989; Mitic & Perkins, 1984). Recent studies have identified cognitive and emotional responses, or coping styles, as having a greater effect (Burnett, Blumenthal, Mark, Leimberger, & Califf, 1995; Dracup & Moser, 1997; McKinley, Moser, & Dracup, 2000). Furthermore, mass campaigns and even smaller community-based educational programs have failed to individualize teaching interventions for the public. Individual patients need or prefer varying amounts and types of information and may use different ways of coping. Tailoring of interventions to match the coping styles and information preferences has been successful in achieving positive outcomes for patients before surgeries and other medical procedures (Caldwell, 1991, Ludwick-Rosenthal & Neufeld, 1993; Martelli, Auerbaugh, Alexander, & Mercuri, 1987). However, there is a lack of research on the relationship of preference of information and coping styles used in primary educational interventions for unexpected medical events, such as AMI.

Review of Literature

Coping Style

Treatment seeking behavior has been studied in detail and has lead to the development of several theories to help guide health professionals in understanding why patients delay, including the self-regulation model (Dracup, Moser, Eisenberg, Meischke, Alonzo, & Braslow, 1995). The theoretical framework employed in this study is Leventhal's self-regulation theory, also known as the common sense model. This well-known theory offers a framework for interpreting delay for AMI symptoms (Leventhal, Meyer, & Nerenz, 1980). The theory was developed under the assumption that patients develop their own "common sense" perception of health and threats to health that lead to personal coping. The model consists of three phases

that patients go through at onset of symptoms. In the first stage, representation, the patient labels the symptoms using general knowledge and personal experience. The second stage, coping, consists of the action taken in response to the health threat (i.e. treatment seeking). The third stage, appraisal, consists of evaluating the response or action taken (Ward, 1993). This model implies the importance of both cognitive and emotional reactions when faced with AMI symptoms. The focus in this study will be on coping, the second stage of the self-regulation theory.

Coping can be defined as “cognitive and behavioral efforts to master, reduce, or tolerate external and internal demands and conflicts” (Strauss, 1988). Coping is, simply, the collective efforts of a person in attempt to manage stress. Several coping strategies exist, and their respective effectiveness is dependent on both the individual and the situation. Lazarus labeled the two main styles of coping as problem-focused and emotion-focused. Using the problem-focused style, a person attempts to gather information to make decisions and take action in efforts to reduce or eliminate the threat. These coping actions may be self or environment-directed. For example, problem-focused coping strategies related to AMI include going to the hospital, or calling a doctor. The emotion-focused style concentrates on regulating emotions evoked by the stressor or threat. Examples of such strategies would be wishing or praying symptoms would go away, or reappraising the situation before taking any action (Lazarus, 2000).

It is clear that although these two major coping styles exist, many actions taken in response to a threat may have characteristics of both strategies. Furthermore, it would be extremely difficult and unlikely for a person to use one style, exclusively, when faced with a stressful event. It is important also to note that one style is not universally more or less effective than the other. However, it may be legitimate to assume that one style, or the emphasis on one style may be more appropriate or effective in certain situations. For example, given a patient experiencing heart attack symptoms, the initial use of problem-focused coping (i.e., calling a

doctor) would be more beneficial than initial use of emotion-focused coping (i.e., pretending nothing is wrong) due to the detrimental effects of delay on morbidity and mortality. Currently, there is little research examining the possible relationship between coping style and pre-hospital delay time for patients experiencing symptoms of AMI.

Preference for Information

To assess the amount of health related information desired by a patient, the measure "preference for information" has been used. It shares a close relationship with coping. Preference for information can be defined as an active coping strategy used to assess and manage stressful situations (Strauss, 1988). Information-seeking also has been described as a model of coping, with coping being the link between information preference, desire for behavioral involvement, and information-seeking behavior in health-related situations that involve risk (Lazarus & Folkman, 1984). Information-seeking can be used to support direct action and/or regulate emotions in a stressful situation, such as the occurrence of AMI (Strauss, 1988). A number of instruments have been developed to measure this preference for information, including the Krantz Health Opinion Survey (Information Subscale), in which the level of preference is related to number of questions asked by patients in health care environments and general desire to be involved in health care decisions (Krantz, Baum, & Wideman, 1980). Information is relayed to patients as a resource to guide appropriate coping. Knowledge of a patient's preference for information is, therefore, very important when preparing educational materials. Furthermore, matching preference level with amount and depth of information can enhance patient outcomes.

A study by Ludwick-Rosenthal and Neufeld in 1993 investigated the effects of information-based preparation and desire for information in patients undergoing cardiac catheterization. The sample group consisted of seventy-two patients ranging from 38 to 75 years of age (M=63.5 years), with an average education of grade 12. There were 36 men and

36 women, all having some cardiac complications. Those with additional complicating medical problems were not included. Each participant was randomly assigned to either a high or low information preparation group. The high information preparation consisted of an 8 minute audio tape, with complementary written text that described the procedure and rationale in great detail. Step-by-step description of the procedure was disclosed, including sensory information, samples of instruments, and diagrams. The low information preparation included a similar audio tape and text format, but lasted only 3 minutes and contained much less detail. Only general description was provided. Prior to the preparation sessions, the participants completed a packet of questionnaires consisting of the Krantz Health Opinion Survey and Miller Behavior Styles Scale to measure information preference, the Desirability of Control Scale to measure preference for control, and ratings of stress and anxiety and pain-discomfort expectancy ratings. Analysis of the data, which revealed no significant differences between groups, indicated that matching information desires with preparatory information level led to lower anxiety, more problem-based coping, and less emotion-based coping in patients undergoing an invasive medical procedure. For information-avoiders, problem-focused coping was impeded by high information preparation. For information-seekers, problem-focused coping was impeded when a high level of information was withheld.

In a 1987 study, Martelli et al. specifically studied the relationship between preference for information and coping styles. A sample of 46 patients scheduled to undergo preprosthetic oral surgery was recruited from a Virginia oral surgery clinic. The sample was characterized by mostly low to lower-middle class participants ranging from 46-74 years of age (M=55 years). The sample was 58.7% female, 57% black, and 43% white. Participants filled out the Ways of Coping Checklist (WCCL; Folkman & Lazarus, 1980), Krantz Health Opinion Survey, Information scale (KHOS-I; Krantz, Baum, & Wideman, 1980), and the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970). The STAI measured level of anxiety. They were then assigned (in an ABCCBA sequence) into problem-focused, emotion-focused, or

mixed-focus intervention group. The problem-focused intervention included objective informational interpretation of the upcoming surgical procedure. The emotion-focused intervention relied mainly on reduction of emotional distress, consisting of instruction on relaxation techniques to be used during the surgery. The mixed-focus intervention combined objective and emotion-related information. When information preference was matched with corresponding interventions patients had the best outcomes, making KHOS-I scores the best overall predictor of patient response to surgery in the presence of the preparatory interventions. The results of the study revealed that the emotion-focused intervention produced better outcomes for those with low preference for information, while those with a high information preference had a better response to surgery when given the problem-focused intervention. The mixed-focus intervention was the most successful, overall. Outcomes were assessed by reports of adjustment and satisfaction as well as self-reported pain and measure of state anxiety (Martelli et al., 1987). Again, this study suggests that preference-matched interventions produced better patient outcomes. While this information is helpful when planning pre-procedural interventions, it does not reveal the significance of preference for information in a generic medical situation or preparation for an unexpected event, such as AMI.

A similar study done by Caldwell in 1991 examined differences in preference for information and its influence on stress and coping. A convenience sample of 69 patients was taken from the ambulatory surgery unit of a 590-bed teaching hospital. These patients were all undergoing outpatient surgery for the first time, were all Caucasian, predominantly female (87%) and married (70%), and ranging in age from 19 to 81 years old (M=37). Before surgery, the participants completed the KHOS-I to assess preference for information, the Speilberger State-trait Anxiety Inventory to assess preoperative stress and anxiety, the Revised Ways of Coping Checklist to assess coping strategies and a brief interview where they were asked about specific concerns or worries regarding their upcoming surgeries. Study results revealed a relationship between high preference for information and lower preoperative stress. However,

preference for information had no influence on percentage of problem-focused strategies used (in comparison with emotion-focused coping). In fact, as a group, the percent of problem-focused coping was relatively low overall, when compared to average samples. One explanation for this could be the fact that they had advanced notice that the surgery was going to take place, and therefore, few major actions could be taken to reduce, or change the reality of the threat. The idea that emotion-focused coping is the predominant strategy used in a situation that cannot be changed has been previously supported (Folkman & Lazarus, 1980). This further suggests the need for studies relating preference for information and coping styles in unplanned medical situations.

The main goal of this study is to further examine factors influencing treatment seeking delay for AMI symptoms, specifically preference for information and coping style. The information preferences and coping styles of patients who have recently experienced AMI will be assessed to determine a possible relationship. The specific goals of this investigation are to determine if level of preference for information is related more or less to problem-focused or emotion-focused coping styles as reported to have been actually used by patients at the onset of AMI symptoms, and if these factors are related to actual delay time to hospital presentation for symptoms. It is hoped that the results of this study will contribute to the body of delay and coping literature and also assist health care professionals in developing successful informational interventions for their patients, resulting in less delay and better health outcomes. If preference for information and coping style are not related to delay time, further research to determine alternate foci for primary prevention interventions would be warranted.

Methods and Design

Research Questions

(1) Is there a difference between high and low preference for information groups in time to presentation for AMI symptoms?

(2) Is there a difference between high and low preference for information groups in coping style?

(3) Is there a difference between initial coping style (problem vs. emotion-focused) in time to presentation for AMI symptoms.

(4) Is there a correlation between delay time and preference for information?

Human Subjects Concern

This study is a secondary analysis of a multisite descriptive study of AMI patients and related complications. Institutional Review Board Approval was obtained for each site in the original study. Participants signed a written consent prior to their participation in the study.

Procedure

Participants from this study were recruited from two cardiac care units in Ohio. For inclusion in the study, patients had to meet the following criteria: (1) confirmed AMI diagnosis, (2) hemodynamilcally stable and relatively pain-free at time of recruitment, (3) English speaking, (4) no cognitive impairments, (5) no non-cardiac serious or life-threatening co-morbidities. Patients were approached within 48 hours of admission in their hospital rooms by trained research assistants who explained the study. Those who agreed to participate signed a written consent and underwent a brief health history interview with the research assistant and completed the Krantz Health Opinion Survey and the modified Response to Symptoms Questionnaire. Additional socioeconomic and medical data were obtained from patients' medical records.

Instruments

The Krantz Health Opinion Survey (KHOS) was developed to measure personal attitudes about information seeking (KHOS-I) and involvement (KHOS-B) in health-related situations. It has shown to have good test-retest reliability (Krantz et al., 1980). This study will use only the information subscale (KHOS-I) to determine preference for information. This

subscale consists of 7 items to which patients relate their agreement or disagreement using a 6-point scale. Scores range from 7-42, with higher score indicating greater desire for health-related information. Cronbach's alpha coefficients for KHOS-I have ranged from .72-.76 in previous studies (Krantz et al., 1980, Strauss, 1990, Garvin et al., 2003). The Cronbach's alpha in this study was .73.

The Response to Symptoms Questionnaire was originally developed to assess factors related to patient responses to AMI symptoms in 6 domains: (1) context of symptom onset, (2) antecedents of symptoms, (3) emotional responses, (4) behavioral responses, (5) cognitive responses, and (6) response of others (Burnett, Blumenthal, Mark, Leimberger, & Califf, 1995). It was modified by Dracup and Moser in 1997 to address additional cognitive, emotional, and social factors deemed important in delay literature. One question from the survey, inquiring about the patients' initial behavioral response to symptoms, will be analyzed. The subjects selected one from twelve choices defined as either problem-focused, emotion-focused, or mixed focus coping strategies. Good content validity has been reported on both the original and modified survey (Dracup & Moser, 1997). Reports of specific internal or external validity or reliability have not been reported.

For the purpose of this study, delay is defined as the time of onset of symptoms leading to help-seeking to actual hospital presentation for treatment. This time is measured in minutes and determined by patient interview and review of medical records. In the brief interview, patients were first asked to make a broad estimation of symptom onset. They were then guided to narrow the time down by placing it in the context of their normal daily activities (after dinner, before bed, etc). Family members and emergency department reports were also consulted for confirmation.

Data Analysis

Demographic data were analyzed with descriptive statistics. KHOS-I scores were split into high and low information preference groups with a median split and were treated as interval

data. Coping styles (problem-focused and emotion-focused) were treated as nominal data. Delay times were treated as interval data. Independent T-tests were obtained to determine possible differences between delay time and (1) level of information preference and (2) initial coping style. A chi-square test examined possible associations between level of information preference and initial coping style. Pearson's r was be used to determine a possible correlation between delay time and preference for information scores.

Results

Patient Characteristics

This sample of 173 Ohio AMI patients was 52% male, 91% Caucasian, and 67% married (see Table 1). The age of the participants ranged from 56 to 87 years and the mean age was 60 ± 13. The income level of 57% of the patients was between $5,000 and $40,000. The mean educational attainment was 13 years. Significant co-morbidities included hypertension (56.6%), diabetes mellitus (26.6%), previous MI (30.1%), previous angina (37.2%), and known coronary artery disease (CAD) history without event (11%). Cardiac procedures within the group included prior PTCA (21.4%), prior stent placement (11%), and prior coronary artery by-pass graft (CABG) (9.8%). At the time of admission 32.6% of participants were smokers.

Delay Times

Delay times ranged from 8 minutes to 25,191 minutes, or about 2 and a half days. The mean delay time, converted into hours, was 15.2 ± 39.5. The median delay time was 3.1 hours and the mode was 1 hour. Since a small number of individuals delayed for an extended period of time, therefore skewing the mean, the median and mode values may be more accurate measures of central tendency than the mean. In this case, the median and mode values reflect much shorter delay times. Forty-three percent of individuals in this sample presented in the period in which implementation of optimal treatment was still possible (3 hours or less). Seventeen percent presented in 1 hour or less and 35.7% presented in 2 hours or less. Unfortunately, over half of the participants (56.7%) delayed more than 3 hours.

Initial Coping Response to Symptoms

Initial coping responses varied greatly in the participants (see Table 2). The most common initial coping strategy (22%) was to “relax”, an emotion-focused response. The next most common response (19%) was to “take medicine”, a problem-focused response. Problem-focused and emotion-focused coping styles were almost equally used, with 52% of the sample using problem-focused coping and 48% using emotion-focused coping strategies as their initial response. Problem-focused strategies included taking medication (19.1%), telling another person about the symptoms (14.4%), trying a self-help remedy (11.6%), transporting self or having another person transport to the hospital (3.5%), calling the emergency system (2.3%), and calling a physician (1.2%). Emotion-focused strategies included relaxing (22%), wishing or praying symptoms would go away (15%), pretending nothing was wrong (6.9%), and trying not to think about the symptoms (4%).

Preference for Information

The KHOS-I scores for this sample ranged from 7 to 42 and the mean was 25 (SD = 7.23). The KHOS-I scores were divided into low (47.4%) and high (52.6%) information groups with a median split. The low and high information groups were used to analyze possible relationships with delay times and coping styles.

Findings by Research Questions

(1) Is there a difference between high and low preference for information groups in time to presentation for AMI symptoms?

The mean time for low preference for information AMI patients’ time to presentation was 11.5 (± 22.4) hours. The mean time for high preference for information patients’ time to presentation was 18.8 (± 50) hours. The t-test revealed no significant difference between high and low information preference groups in time to presentation (t = -1.169, df = 169, p = .244). See Table 3.

(2) Is there a difference between high and low preference for information groups in coping style?

The chi-square revealed no significant difference between high and low information preference groups and coping style (x^2 = 1.037, p = .361). See Table 4

(3) Is there a difference between initial coping style (problem vs. emotion-focused) in time to presentation for AMI symptoms?

The mean time for patients who used problem-focused coping to presentation was 12.8 (± 45.7) hours. The mean time for patients who used emotion-focused coping to presentation was 17.7 (± 31.7) hours.

The t-test revealed no significant difference between problem and emotion-focused coping groups and delay time (t = .823, df = 169, p = .412). See Table 5.

(4) Is there a correlation between delay time and preference for information?

There was not a significant correlation between delay time and preference for information (r = .04, p = .617). See Table 6.

Analysis of the research questions revealed no statistically significant results. Significant relationships were not determined between patient delay times, initial coping response, and or preference for information. Results of data analysis of all research questions can be found in tables 3, 4, 5, and 6.

Discussion

Interpretation of results

The median delay time of 3.1 hours in this sample was similar to the averages, ranging from approximately 1.5 to 4 hours, reported in past studies, while the mean delay time of over 15 hours was longer (Dracup & Moser,1991; Burnett et al., 1995; Berton et al., 2001; Walsh, Lynch, Murphy, & Daly, 2004). Initial coping styles were split almost equally between emotion and problem-focused coping, and had no relationship with delay time or level of preference for information. Previous studies reported more problem-focused coping than in this sample, but

similarly did not find significant relationships between coping style and delay time (Dracup et al., 1997; McKinley et al., 2000). In contrast, a study by Walsh et al. (2004), found that coping style was an important predictor of delay. They reported that problem-focused coping contributed significantly to shorter delay times.

Although past studies have examined coping response in relationship to treatment-seeking delay for AMI symptoms, this is the first study to also examine the possible influence of preference for information. Determining the use of patient level of preference for information is very complex, and proved so in this study. As a whole, the group of participants had a moderate preference for information with a mean score of 25. These results are similar to those found in studies of both AMI patients and those undergoing cardiac catheterization (Garvin & Kim, 2000; Garvin et. al, 2003). Few subjects had very high or very low information preference, although preferences ranged from the highest to lowest KHOS-I scores. In this study, preference for information scores had no relationship with delay times or initial coping style, while another study examining cardiac catheterization patients found that patients with higher preference for information engaged in more problem-focused coping than those in the low preference for information group (Ludwick-Rosenthal & Neufeld, 1993). Other studies examining preference for information in cardiac patients, especially those experiencing AMI, are needed for further comparison.

Some results of this study may have been skewed by the high occurrence of cardiac-related co-morbidities in the sample. Previous studies disagree whether or not significant co-morbidities, especially previous AMI, may affect both delay times and coping responses to AMI symptoms. In an attempt to confirm or reject these assumptions, further analysis was done to compare results of patients who had previously experienced AMI with those who had not. Although average delay times were still high, those in the sample with a history of previous AMI had a shorter mean delay time (11.5 ± 18.6 hours) than those with no history of AMI (16.7 ± 45.6). This difference, however, was not significant. Similar results were reflected in findings of

several previous studies (Berton & Cordiano, et al, 2001; Burnett & Blumenthal et. al, 1995; McKinley & Moser et. al, 2000). The patients in this study who had previously experienced AMI also used problem-focused coping more often (61.5%) than the group with no previous AMI (47.9%), although this was not significant. The effect of co-morbidities on preference on information has not been studied previously, therefore, further study is needed.

Limitations

One major limitation of this study is due to the fact it was a secondary analysis. While the study yielded a moderate number of subjects and amount of data, the design made it hard to carefully analyze patient coping style. The Response to Symptoms Questionnaire offered the opportunity only to determine each subjects' initial response to the symptoms that ultimately led them to seek medical treatment. It cannot be generalized that the initial behavioral response or coping style used by the patient was the only or even predominant coping style. Additionally, the KHOS-I reliability correlation of .72 may not be high enough to accurately predict significant results. This study also failed to analyze the symptoms that were manifested in each patient.

Implications

According to the first stage of the self-regulation theory, representation, the patient labels the symptoms using general knowledge and personal experience. The second stage, coping, consists of the action taken in response to the health threat (i.e. treatment seeking). The third stage, appraisal, consists of evaluating the response or action taken. The results of this study suggest the importance of each stage of this theory for patients experiencing symptoms of AMI and for the formulation of interventions to reduce delay. The first stage alludes to the importance of knowledge of AMI symptoms necessary to accurately label symptoms as they are experienced. It highlights the significance of symptom recognition and appraisal in the coping response process. Labeling symptoms improperly may lead to inappropriate or counterproductive coping in the next stage. Nursing implications related to this stage include patient teaching of symptoms commonly related to AMI. This teaching should take into

consideration important sociodemographic characteristics including patient gender, age, and health history. The second stage of the process suggests the importance of effective coping responses to AMI symptoms. Nursing implications include proper teaching of acceptable and beneficial coping responses crucial for this stage. The appraisal stage requires reapplication of the same knowledge used in the first two stages in order to determine whether or not the cycle must be repeated and additional coping responses must be undertaken to remedy the symptoms and promote optimum recovery. The self-regulation theory and the results of this study emphasize the value of socidemographic, cognitive, and emotional factors in the treatment-seeking process for AMI symptoms. The results of this study also suggest the need for further research to reveal additional factors associated with treatment-seeking delay as well as methods to reduce delay times.

Table 1

Sociodemographic and Clinical Characteristics of 173 Ohio AMI Patients

	Total (N=173)	Percent (%)
Sex	83	48.0
Female	90	52.0
Male		
Age (years)	60±13*	
Race		
African-American	15	8.7
Caucasian	156	90.7
Hispanic	1	.6
Marital Status		
Co-habitate	1	1.6
Married	116	67.1
Single**	9	5.2
Widowed	25	14.5
Education (years)	13±3*	
Income		
<$5,000	11	6.4
$5,000-20,000	47	27.2
$20,001-40,000	51	29.5
$40,001-60,000	31	17.9
>$60,000	18	10.4
Previous AMI	52	30.1
Previous angina	64	37.0
Hypertension	37	21.0
Known CAD history without event	19	11.0

Note: Column percents may not equal 100% and totals may vary due to missing data

*Mean ± SD

**Single includes single, divorced, and separated

Table 2

Initial Patient Coping Response to AMI Symptoms (n=173)

Emotion-focused coping	Frequency	Percent	Problem-focused coping	Frequency	Percent
Tried to relax	38	22.0	Took medicine	33	19.1
Wished or prayed they would go away	26	5.0	Told someone	25	14.4
Pretended nothing was wrong	12	6.9	Tried self-help remedy	20	11.6
Tried not to think about symptoms	7	4.0	Transported self or had someone transport to the hospital	6	3.5
			Called the emergency system	4	2.3
			Called doctor	2	1.2
Total	83	47.9		90	52.1

Table 3

Mean Delay Time in Hours for High and Low Information Preference AMI Patients (n=171)

	Number of patients	Percent (%)	Mean ± SD
Low Preference for Information	90	52.6	11.5 ± 22.4
High Preference for Information	81	47.4	18.8 ± 50
Total	171	100	15.2 ± 39.5

t = -1.169 df = 169 p = .244

Table 4

Frequencies and Percents of Problem and Emotion Focused Coping in High and Low Information Preference AMI Patients (n=173)

	Problem-focused	Emotion- focused
High information preference	44 (48.4%)	47 (51.6%)
Low information preference	46 (56.1%)	36 (43.9%)

$x^2 = 1.037$ $p = .361$

Table 5

Mean Delay Time in Hours for AMI Patients Using Problem and Emotion Focused Coping as Initial Coping Style (n=171)

Coping style	Number of patients	Percent	Mean ± SD
Emotion-focused	83	48.5	17.7±31.7
Problem-focused	88	51.5	12.8±45.7
Total	171	100	15.2 ± 39.5

t = .823 df = 169 p = .412

Table 6

Correlation of Delay Time and Level of Information Preference for AMI Patients (n=173)

	Delay time	*p*
Preference for information	.04	.617

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